Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012007	A. BUILDING _____ B. WING _____	R 04/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING INDEPENDENT ASSISTED LIVING (	2400 MARKET ST CHARLESTOWN, IN 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 1/12/2012. Survey date: April 13, 2012 Facility number: 012007 Provider number: 012007 AIM number: N/A Survey Team: Dorothy Navetta, RN TC Avona Connell, RN Donna Groan, RN Census bed type: Residential: 65 Total: 65 Census payor type: Other: 65 Total: 65 Sample: 4 River Crossing Independent Assisted Living Community was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure Survey. Quality review completed on April 18, 2012 by Bev Faulkner, R.N.	{R 000}		